		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044198

Facility Name: NORTHWOODS CARE CENTRE

Address: 2250 S. PEARL STREET (Number) BELVIDERE (City) 61108 (Zip Code)

County: BOONE

Telephone Number: (814) 544-0358 **Fax #** (815) 544-5006

IDPA ID Number: 36-3954529

Date of Initial License for Current Owners: 06/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,594	4,907	4,154	21,655	8
9	SNF/PED					9
10	ICF	12,208	4,783	1,184	18,175	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,802	9,690	5,338	39,830	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.94%

D. How many bed-hold days during this year were paid by Public Aid?
95 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 118 and days of care provided 2,744

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	183,316	8,685	6,465	198,466		198,466	3,041	201,507			1
2	Food Purchase		140,364		140,364		140,364	(1,554)	138,810			2
3	Housekeeping	253,805	35,999	0	289,804		289,804	35	289,839			3
4	Laundry	40,168	19,117	388	59,673		59,673	361	60,034			4
5	Heat and Other Utilities			64,503	64,503		64,503	0	64,503			5
6	Maintenance	24,920	28,028	15,062	68,010		68,010	(711)	67,299			6
7	Other (specify):*			3,838	3,838		3,838	0	3,838			7
8	**TOTAL General Services**	502,209	232,193	90,256	824,658	0	824,658	1,172	825,830			8
	B. Health Care and Programs											
9	Medical Director	0		3,000	3,000		3,000	0	3,000			9
10	Nursing and Medical Records	1,366,818	101,419	31,744	1,499,981		1,499,981	5,678	1,505,659			10
10a	Therapy	1,563		6,872	8,435		8,435	0	8,435			10a
11	Activities	123,152	9,090	567	132,809		132,809	508	133,317			11
12	Social Services	49,883		908	50,791		50,791	0	50,791			12
13	Nurse Aide Training			3,971	3,971		3,971	0	3,971			13
14	Program Transportation			0	0		0	0	0			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,541,416	110,509	47,062	1,698,987	0	1,698,987	6,186	1,705,173			16
	C. General Administration											
17	Administrative	99,375		419,617	518,992		518,992	(410,822)	108,170			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			146,523	146,523		146,523	110,051	256,574			19
20	Dues, Fees, Subscriptions & Promotions			45,397	45,397		45,397	(32,908)	12,489			20
21	Clerical & General Office Expenses	99,421	23,572	30,477	153,470		153,470	85,212	238,682			21
22	Employee Benefits & Payroll Taxes			355,117	355,117		355,117	0	355,117			22
23	Inservice Training & Education			4,226	4,226		4,226	0	4,226			23
24	Travel and Seminar			0	0		0	7,664	7,664			24
25	Other Admin. Staff Transportation			4,868	4,868		4,868	0	4,868			25
26	Insurance-Prop.Liab.Malpractice			9,786	9,786		9,786	89,714	99,500			26
27	Other (specify):*			13,026	13,026		13,026	(13,026)	0			27
28	**TOTAL General Administration**	198,796	23,572	1,029,037	1,251,405	0	1,251,405	(164,115)	1,087,290			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,242,421	366,274	1,166,355	3,775,050	0	3,775,050	(156,757)	3,618,293			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,699	63,699		63,699	50,617	114,316			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			79,575	79,575		79,575	75,815	155,390			32
33	Real Estate Taxes			71,986	71,986		71,986	0	71,986			33
34	Rent-Facility & Grounds			515,260	515,260		515,260	(509,752)	5,508			34
35	Rent-Equipment & Vehicles			9,563	9,563		9,563	4,958	14,521			35
36	Other (specify):* STORAGE			1,728	1,728		1,728	0	1,728			36
37	**TOTAL Ownership**			741,811	741,811	0	741,811	(378,362)	363,449			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		74,723	143,556	218,279		218,279	0	218,279			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			65,700	65,700		65,700	0	65,700			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	74,723	209,256	283,979	0	283,979	0	283,979			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,242,421	440,997	2,117,422	4,800,840	0	4,800,840	(535,119)	4,265,721			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,029)	30		9
10	Interest and Other Investment Income	(71,361)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,554)	2		13
14	Non-Care Related Interest	(8,214)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(45)	21		18
19	Entertainment	0	20		19
20	Contributions	(4,158)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(1,421)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,026)	27		24
25	Fund Raising, Advertising and Promotional	(30,071)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(65)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(2,479)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (161,423)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(373,696)	PG 6, 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (373,696)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (535,119)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

NORTHWOODS CARE CENTRE

ID# 0044198

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -221	6	1
2	VACATION ACCRUAL	3,041	1	2
3	VACATION ACCRUAL	35	3	3
4	VACATION ACCRUAL	361	4	4
5	VACATION ACCRUAL	(490)	6	5
6	VACATION ACCRUAL	(1,652)	10	6
7	VACATION ACCRUAL	508	11	7
8	VACATION ACCRUAL	(2,380)	17	8
9	VACATION ACCRUAL	(1,681)	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,479)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	3,041	0	0	0	0	0	0	0	0	0	0	3,041	1
2	Food Purchase	(1,554)	0	0	0	0	0	0	0	0	0	0	(1,554)	2
3	Housekeeping	35	0	0	0	0	0	0	0	0	0	0	35	3
4	Laundry	361	0	0	0	0	0	0	0	0	0	0	361	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(711)	0	0	0	0	0	0	0	0	0	0	(711)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	1,172	0	0	0	0	0	0	0	0	0	0	1,172	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,652)	7,330	0	0	0	0	0	0	0	0	0	5,678	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	508	0	0	0	0	0	0	0	0	0	0	508	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(1,144)	7,330	0	0	0	0	0	0	0	0	0	6,186	16
	C. General Administration													
17	Administrative	(2,380)	(408,442)	0	0	0	0	0	0	0	0	0	(410,822)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,421)	3,557	107,915	0	0	0	0	0	0	0	0	110,051	19
20	Fees, Subscriptions & Promotions	(34,294)	1,386	0	0	0	0	0	0	0	0	0	(32,908)	20
21	Clerical & General Office Expenses	(1,726)	86,251	687	0	0	0	0	0	0	0	0	85,212	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,664	0	0	0	0	0	0	0	0	0	7,664	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,461	87,253	0	0	0	0	0	0	0	0	89,714	26
27	Other (specify):*	(13,026)	0	0	0	0	0	0	0	0	0	0	(13,026)	27
28	TOTAL General Administration	(52,847)	(307,123)	195,855	0	0	0	0	0	0	0	0	(164,115)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,819)	(299,793)	195,855	0	0	0	0	0	0	0	0	(156,757)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(29,029)	3,938	75,708	0	0	0	0	0	0	0	0	50,617	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(79,575)	0	155,390	0	0	0	0	0	0	0	0	75,815	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	5,508	(515,260)	0	0	0	0	0	0	0	0	(509,752)	34
35	Rent-Equipment & Vehicles	0	4,958	0	0	0	0	0	0	0	0	0	4,958	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(108,604)	14,404	(284,162)	0	0	0	0	0	0	0	0	(378,362)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(161,423)	(285,389)	(88,307)	0	0	0	0	0	0	0	0	(535,119)	45

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF	SEE ATTACHED LIST OF RELATED			FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS	NURSING HOMES			(DIVISION OF FHC ENTERPRISE, INC.		CONSULTANT
					ROSEMONT	
				NORTHWOODS HEALTHCARE CENTRE		REAL ESTATE
					ROSEMONT	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING	$	FHC ENTERPRISES INC.		$ 7,330	$ 7,330	1
2	V	17	ADMINISTRATIVE	419,617	MR. BELLOWS OWNS 57% OF THIS FACILITY		11,175	(408,442)	2
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISES		3,557	3,557	3
4	V	20	DUES & SUBSCRIPTIONS		" "		1,386	1,386	4
5	V	21	CLERICAL		" "		86,251	86,251	5
6	V	24	TRAVEL		" "		7,664	7,664	6
7	V	26	INSURANCE		" "		2,461	2,461	7
8	V	30	DEPRECIATION		" "		3,938	3,938	8
9	V	34	RENT		" "		5,508	5,508	9
10	V	35	RENT- EQUIPMENT & VEH.		" "		4,958	4,958	10
11	V								11
12	V								12
13	V								13
14	Total			$ 419,617			$ 134,228	$ * (285,389)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 515,260	NORTHWOODS HEALTHCARE CENTRE		$	$ (515,260)	15
16	V	19	ACCOUNTING		" "		7,500	7,500	16
17	V	19	LEGAL		" "		340	340	17
18	V	19	OTHER PROFESSIONAL		" "		100,075	100,075	18
19	V	21	BANK CHARGES		" "		687	687	19
20	V	26	GENERAL INSURANCE		" "		77,260	77,260	20
21	V	26	MORTGAGE INSURANCE		" "		9,993	9,993	21
22	V	30	DEPRECIATION		" "		75,708	75,708	22
23	V	32	AMORTIZATION		" "		1,756	1,756	23
24	V	32	INTEREST - MORTGAGE		" "		149,334	149,334	24
25	V	32	INTEREST - OTHER		" "		4,300	4,300	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 515,260			$ 426,953	$ * (88,307)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHAEL BELLOWS	MNGMT CNSLT	ADMINISTRATIV	0.57	SEE ATTACHED	1.5	7.94	SALARY	11,175	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,175		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	501,904	10	$ 92,369	$ 92,369	39,830	$ 7,330	1
2	17	ADMINISTRATIVE	PATIENT DAYS	501,904	10	140,817	140,817	39,830	11,175	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	501,904	10	44,800		39,830	3,557	3
4	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	501,904	10	17,462		39,830	1,386	4
5	21	CLERICAL	HOURS WORKED	501,904	10	130,659		39,830	10,369	5
6	24	TRAVEL	PATIENT DAYS	501,904	10	96,528		39,830	7,664	6
7	26	INSURANCE	PATIENT DAYS	501,904	10	30,995		39,830	2,461	7
8	30	DEPRECIATION	PATIENT DAYS	501,904	10	49,603		39,830	3,938	8
9	34	RENT	PATIENT DAYS	501,904	10	69,364		39,830	5,508	9
10	35	RENT-EQUIPMENT & VEH.	PATIENT DAYS	501,904	10	62,438		39,830	4,958	10
11	21	CLERICAL	PATIENT DAYS	1	1	75,877	75,877	1	75,882	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 810,912	$ 309,063		$ 134,228	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	GMAC		X	MORTGAGE		10/97	$ 2,052,500	$ 1,994,123		7.4500	$ 149,334	1
2	GMAC		X	LOAN COST			61,456	53,993			1,756	2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	LINE OF CREDIT	VARIES	12/00	975,000	885,000	DEMAND	PRIME +	64,139	6
7	RELATED PARTIES	X		WORKING CAPITAL	VARIES	VARIES	173,297	94,823	DEMAND	PRIME +	4,492	7
8	CRESTWOOD HEIGHTS	X		WORKING CAPITAL	VARIES	12/98	75,000	94,561	DEMAND	VARIES	7,030	8
9	TOTAL Facility Related						$ 3,337,253	$ 3,122,500			$ 226,751	9
	B. Non-Facility Related*											
10												10
11	NORTHWOODS HEALTHCAI	X		WORKING CAPITAL	DEMAND	VARIES	238,870	110,487	DEMAND	VARIES	8,214	11
12												12
13												13
14	TOTAL Non-Facility Related						$ 238,870	$ 110,487			$ 8,214	14
15	TOTALS (line 9+line14)						$ 3,576,123	$ 3,232,987			$ 234,965	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 68,388	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 69,802	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,414	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 70,572	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 71,986	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	78,776	8
	1997	66,995	9
	1998	67,231	10
	1999	67,637	11
	2000	69,802	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWOODS CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044198

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-01-151-003	NURSING HOME	$ 69,801.64	$ 69,801.64
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,801.64	$ 69,801.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2/BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1981	$ 50,050	1
2	754 BASIS ADJ.		1992	4,835	2
3	TOTALS			$ 54,885	3

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1981		$ 995,068	$ 0	30	$ 33,169	$ 33,169	$ 696,549	4
5	754 BASIS ADJ		1992		111,968	3,555	31.5	3,555		33,770	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE										9
10	VARIOUS IMPROVEMENTS			1981	4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS			1982	73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS			1983	6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS			1984	11,372	291	20	569	278	9,959	13
14	PAVING			1986	13,000	653	15	867	214	13,438	14
15	SHOWER			1986	4,151	205	25	166	(39)	2,573	15
16	ROOF			1988	38,383	1,219	31.5	1,219		16,507	16
17	DECORATING			1989	1,921	61	31.5	61		750	17
18	VARIOUS IMPROVEMENTS			1990	10,047	319	31.5	319		3,828	18
19	VARIOUS IMPROVEMENTS			1991	2,683	85	31.5	85		1,018	19
20	VARIOUS IMPROVEMENTS			1992	38,565	1,224	31.5	1,224		11,390	20
21	CARPET			1993	6,854	217	31.5	217		1,887	21
22	DRIVEWAY			1993	1,655	42	39	42		340	22
23	SPRINKMAN SONS			1993	1,525	39	39	39		283	23
24	VARIOUS IMPROVEMENTS			1994	3,137	209	15	209		1,567	24
25	VARIOUS IMPROVEMENTS			1994	170,951	6,216	27.5	6,216		39,175	25
26	DOORS			1995	5,029	129	39	124	(5)	884	26
27	LANDSCAPING			1996	51,185	1,861	27.5	1,861		9,903	27
28	ROOF REPAIR			1996	20,000	727	27.5	727		3,742	28
29	DRIVEWAY REPAIR			1996	4,775	174	27.5	174		864	29
30	CONCRETE RETAINING WALL FOR RAMP			1997	1,500	55	27.5	55		238	30
31	WALL COVERING/HANDRAIL/FLOOR TILES			1997	46,256	1,682	27.5	1,682		7,173	31
32	DRYWALL/PAINTING/WALL PAPER INSTALLATION			1997	30,000	1,091	27.5	1,091		4,546	32
33	450000-GRAIN UNITS-WATER SOFTENER/COUNTER TOPS			1997	11,248	409	27.5	409		1,696	33
34	THREE WAY OVER BED RESIDENT LIGHTING			1998	12,600	458	27.5	458		1,495	34
35	GARBAGE DISPOSAL-KITCHEN REMODELING			1998	1,189	43	27.5	43		149	35
36	WINDOWS AND AUTO DOOR SYSTEM			1998	25,000	909	27.5	909		2,992	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	$ 68,941	$ 2,507	27.5	$ 2,507	$	$ 9,335	37
38	TILES	1998	3,164	115	27.5	115		417	38
39	WOOD FLOORING	1998	4,705	171	27.5	171		591	39
40	COUNTER TOPS	1998	17,763	646	27.5	646		2,229	40
41	ELECTRICAL WIRING	1998	3,675	134	27.5	134		474	41
42	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		15,667	42
43	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		3,124	43
44	RMODELING-HALLS/REHAB/OFFICES WASHROOMS	1999	100,000	3,636	27.5	3,636		10,454	44
45	TILES	1999	3,924	143	27.5	143		304	45
46	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	96	27.5	96		204	46
47	REMODELING-ARCHITECTURE	2000	4,000	145	27.5	145		284	47
48	BLACKTOP STRIPPING & SEALING	2000	4,050	270	15	270		405	48
49	AIRTHERM HEATERS	2000	34,363	1,249	27.5	1,249		1,614	49
50	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	85	15	85		85	50
51	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	53	27.5	53		53	51
52	FIRE ALARM PANEL	2001	2,388	54	27.5	54		54	52
53	SPEED BUMPS - PARKING LOT	2001	3,600	120	15	120		120	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61			ADJ TO SL	33,617			(33,617)		61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,115,624	$ 70,515		$ 70,515	$ 0	$ 995,846	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 439,442	$ 58,140	$ 32,641	$ (25,499)	3-15 YRS	$ 128,771	71
72	Current Year Purchases	34,916	5,559	2,029	(3,530)	3-15 YRS	2,029	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTIES	410,783	9,131	9,131	0		398,728	74
75	TOTALS	$ 885,141	$ 72,830	$ 43,801	$ (29,029)		$ 529,528	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,055,650	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 143,345	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 114,316	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (29,029)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,525,374	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 5,188 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	1999 DODGE RAM-VAN	$ 625.00	$ 4,375	17
18					18
19					19
20					20
21	TOTAL		$ 625.00	$ 4,375	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[X]
HOURS PER AIDE	90

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[X]
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 3,532	$	$ 3,532
2	Books and Supplies		184		184
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests		255		255
9	TOTALS	$ 0	$ 3,971	$ 0	$ 3,971
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,971			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs		$		$ 59,781	$		$ 59,781	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				11,203			11,203	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				70,643			70,643	4
5	Physician Care	39-3	visits				1,929			1,929	5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					60,468		60,468	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2						14,255		14,255	13
14	TOTAL				$		$ 143,556	$ 74,723		$ 218,279	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 35,167	$ 81,413	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 73,281)	948,608	948,608	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,081	1,081	5
6	Prepaid Insurance	23,949	106,080	6
7	Other Prepaid Expenses	1,300	1,300	7
8	Accounts Receivable (owners or related parties)	1,840,635	2,621,165	8
9	Other(specify): ESCROW DEPOSITS		54,725	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,850,740	$ 3,814,372	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,008,589	15
16	Equipment, at Historical Cost	474,357	884,424	16
17	Accumulated Depreciation (book methods)	(313,403)	(1,894,334)	17
18	Deferred Charges		53,993	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		308,562	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 160,954	$ 1,406,352	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,011,694	$ 5,220,724	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 201,370	$ 264,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	84,600	84,600	28
29	Short-Term Notes Payable	1,099,871	1,189,171	29
30	Accrued Salaries Payable	53,428	53,428	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,316	6,316	31
32	Accrued Real Estate Taxes(Sch.IX-B)		70,572	32
33	Accrued Interest Payable	117	117	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	214,379	214,379	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,660,081	$ 1,883,302	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	63,104	63,104	39
40	Mortgage Payable		1,994,123	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 63,104	$ 2,057,227	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,723,185	$ 3,940,529	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,288,509	$ 1,280,195	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,011,694	$ 5,220,724	48

*(See instructions.)

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 537,261	1
2	Restatements (describe):		2
3	**ROUNDING ADJ.**	7	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 537,268	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	751,241	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 751,241	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,288,509	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,394,166	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,394,166	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	728	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 728	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	157,187	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 157,187	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,552,081	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	824,658	31
32	Health Care	1,698,987	32
33	General Administration	1,251,405	33
	B. Capital Expense		
34	Ownership	741,811	34
	C. Ancillary Expense		
35	Special Cost Centers	218,279	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,800,840	40
41	**Income before Income Taxes (line 30 minus line 40)****	751,241	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 751,241	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,755	2,996	$ 77,429	$ 25.84	1
2	Assistant Director of Nursing	2,117	2,358	45,977	19.50	2
3	Registered Nurses	15,328	16,861	371,970	22.06	3
4	Licensed Practical Nurses	12,152	13,519	223,083	16.50	4
5	Nurse Aides & Orderlies	49,224	53,185	589,011	11.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	111	111	1,563	14.08	8
9	Activity Director	1,997	2,198	28,131	12.80	9
10	Activity Assistants	13,415	14,255	95,021	6.67	10
11	Social Service Workers	3,329	3,837	49,883	13.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	7,878	8,996	101,161	11.25	14
15	Cook Helpers/Assistants	8,990	9,996	82,155	8.22	15
16	Dishwashers					16
17	Maintenance Workers	2,174	2,347	24,920	10.62	17
18	Housekeepers	27,997	29,839	253,805	8.51	18
19	Laundry	5,141	5,344	40,168	7.52	19
20	Administrator	1,941	2,085	99,375	47.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,712	6,426	99,421	15.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,908	4,366	59,348	13.59	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	164,169	178,719	$ 2,242,421 *	$ 12.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	182	$ 6,465	1-3	35
36	Medical Director	24	3,000	9-3	36
37	Medical Records Consultant	16	1,000	10-3	37
38	Nurse Consultant	244	9,489	10-3	38
39	Pharmacist Consultant	230	1,380	10-3	39
40	Physical Therapy Consultant	55	3,232	10a-3	40
41	Occupational Therapy Consultant	56	3,640	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	11	567	11-3	44
45	Social Service Consultant	17	908	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT	145	7,275	10a-3	47
48	U.R. CONSULTANT	36	12,600	10a-3	48
49	TOTAL (lines 35 - 48)	1,016	$ 49,556		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN MEAD	ADMIN		$ 99,375
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 99,375

B. Administrative - Other

Description		Amount
FIRST HEALTH CARE	MANAGEMENT FEES	$ 419,617
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 419,617

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		146,523
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 146,523

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,463
Unemployment Compensation Insurance	13,849
FICA Taxes	168,987
Employee Health Insurance	108,218
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,035
EMPLOYEE PHYSICAL EXAMS	2,448
PENSION/PROFIT SHARING PLANS	9,117
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 355,117

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,802
Health Care Worker Background Check	1,043
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	30,136
RELATED PARTY	1,386
CONTRIBUTIONS	4,158
DUES & SUBSCRIPTIONS	4,910
LICENSES & PERMITS	348
LESS: CONTRIBUTIONS	(4,158)
Less: Public Relations Expense	(0)
Non-allowable advertising	(30,071)
Yellow page advertising	(65)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,489

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MANAGEMENT COMPANY ALLOC.	7,664
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,664

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATIONG	1997	$ 3,488	3	$ 1,163	$ 1,163	$ 581	$	$	$	$	$	$
2	PAINT/DECORATIONG	1998	1,534	3	256	511	511	256					
3	PAINT/DECORATIONG	2000	2,497	3			416	832	832	417			
4	PAINT/DECORATIONG	2001	1,571	3				262	524	524	261		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,090		$ 1,419	$ 1,674	$ 1,508	$ 1,350	$ 1,356	$ 941	$ 261	$	$

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $6144.00

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,882 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,700
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,465	
	REPAIRS & MAINTENANCE		0	
			0	6,465
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		388	
			0	388
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		12,618	
	ELECTRICITY		34,747	
	WATER		16,413	
	CABLE TV - LOBBY		725	
			0	64,503
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		665	
	PAINTING & DECORATING		1,571	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,714	
	ELEVATOR MAINTENANCE & REPAIR		3,218	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		555	
	FIRE SERVICE		1,339	
			0	
			0	
			0	15,062
7	**OTHER**			
	SCAVENGER		3,838	
	SECURITY SERVICE		0	3,838
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	3,000	3,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	7,275	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,000	
	PHARMACY CONSULTANT	XVIII B 39-2	1,380	
	UTILIZATION REVIEW FEES	XVIII B 48-2	12,600	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	9,489	
			0	
			0	31,744
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,232	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	3,640	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	6,872
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	567	
			0	567
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	770	
	SOCIAL WORKER	XVIII B 45-2	138	
			0	908
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	3,971	3,971

Facility Name & ID Number NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	419,617	419,617
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	17,039	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	129,484	
			0	146,523
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	30,071	
	EMPLOYEE WANT ADS	XIX F	4,802	
	CONTRIBUTIONS	VI 20 XIX F	1,142	
	DUES & SUBSCRIPTIONS	XIX F	4,910	
	LICENSES & PERMITS	XIX F	348	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	65	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,016	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,043	45,397
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		314	
	EQUIPMENT REPAIR & MAINTENANCE		1,496	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	45	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		100	
	TELEPHONE		28,484	
	MESSENGER SERVICE		38	
			0	30,477

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	168,987	
	UNEMPLOYMENT COMPENSATION	XIX D	13,849	
	WORKERS COMPENSATION INSURANC	XIX D	41,463	
	HOSPITALIZATION INSURANCE	XIX D	108,218	
	EMPLOYEE BENEFITS - OTHER	XIX D	11,035	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,448	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	9,117	
	CHICAGO HEAD TAX	XIX D	0	355,117
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,226	4,226
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,868	4,868
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		9,786	9,786
27	**OTHER**			
	BAD DEBTS	VI 24	13,026	
			0	13,026

GRAND TOTAL COLUMN 3 OTHER 1,166,355

NORTHWOODS CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	140,364
LESS SALES TAX	(1,554)
NET FOOD	141918
TOTAL PATIENT CENSUS	39,830
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	119490
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	119490
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	119490
NET FOOD	141918
DIVIDE TOTAL MEALS/YEAR	119490
COST PER MEAL	1.19
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0

NORTHWOODS CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2001

INCOME PER F/S									5,026,938	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,698,987	355,117	426,155	59,673	338,830	896,288	65,700	741,811		2,242,421
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	2,045		3,143			4,375		(9,563)		
CABLE TV			(725)			725				
CONTRACT NURSING										
INTEREST INCOME							(157,187)			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		(2,448)				2,448				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						(419,617)		419,617		
RESIDENT TAX REBILLED - PVT										
BAD DEBTS						(13,026)	13,026			
DISCOUNTS LOST							0			
AMORT-COMP SOFTWARE								0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	(148,949)	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	(728)	0		
TOTAL COSTS	1,701,032	352,669	428,573	59,673	338,830	471,193	(228,138)	1,151,865	4,275,697	2,242,421
PER FINANCIAL STATEMENTS	1,701,032	352,669	428,573	59,673	338,830	471,193	(228,138)	1,151,865	751,241	2,242,421
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									751,241	

NORTHWOODS CARE CENTRE - COMPARISONS - 12/31/2001

	ref.	12/31/2001			12/31/2000			DIFF	12/31/1999		
CAPACITY DAYS		43,800			43920			(120)	43800		
CENSUS DAYS		39,830			40073			(243)	41001		
OCCUPANCY %		90.94%			91.24%				93.61%		
SALARIES											
TOTAL General Services	8-1	502,209	11.77%	12.61	444806	11.21%	11.10	57,403	378420	10.47%	9.23
Social Services	12-1	49,883	1.17%	1.25	44536	1.12%	1.11	5,347	43355	1.20%	1.06
TOTAL Health Care and Programs	16-1	1,541,416	36.13%	38.70	1565685	39.46%	39.07	(24,269)	1489308	41.21%	36.32
Clerical & General Office Expenses	21-1	99,421	2.33%	2.50	93491	2.36%	2.33	5,930	87100	2.41%	2.12
TOTAL General Administration	28-1	198,796	4.66%	4.99	194487	4.90%	4.85	4,309	182654	5.05%	4.45
TOTAL Operation Expense	29-1	2,242,421	52.57%	56.30	2204978	55.57%	55.02	37,443	2050382	56.73%	50.01
ADJUSTED TOTALS											
Food	2-8	138,810	3.25%	3.49	135338	3.41%	3.38	3,472	135620	3.75%	3.31
Heat and Other Utilities	5-8	64,503	1.51%	1.62	58237	1.47%	1.45	6,266	73450	2.03%	1.79
Maintenance	6-8	67,299	1.58%	1.69	86038	2.17%	2.15	(18,739)	98348	2.72%	2.40
TOTAL General Services	8-8	825,830	19.36%	20.73	738484	18.61%	18.43	87,346	698054	19.31%	17.03
Administrative	17-8	108,170	2.54%	2.72	109107	2.75%	2.72	(937)	105701	2.92%	2.58
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	256,574	6.01%	6.44	212375	5.35%	5.30	44,199	136337	3.77%	3.33
Fees, Subscriptions, Promotions	20-8	12,489	0.29%	0.31	21507	0.54%	0.54	(9,018)	11776	0.33%	0.29
License Fee-IDPA	Pg21	0	0.00%	0.00	200	0.01%	0.00	(200)	200	0.01%	0.00
License Fee-Other	Pg21	348	0.01%	0.01	7829	0.20%	0.20	(7,481)	371	0.01%	0.01
Clerical & General Office Expenses	21-8	238,682	5.60%	5.99	227733	5.74%	5.68	10,949	209097	5.79%	5.10
Employee Benefits & Payroll Taxes	22-8	355,117	8.32%	8.92	328407	8.28%	8.20	26,710	308210	8.53%	7.52
Payroll Taxes	Pg21	182,836	4.29%	4.59	182982	4.61%	4.57	(146)	171061	4.73%	4.17
W/C Insurance	Pg21	41,463	0.97%	1.04	35360	0.89%	0.88	6,103	27981	0.77%	0.68
Health Insurance	Pg21	108,218	2.54%	2.72	86734	2.19%	2.16	21,484	86766	2.40%	2.12
Inservice Training & Education	23-8	4,226	0.10%	0.11	6475	0.16%	0.16	(2,249)	7740	0.21%	0.19
Travel and Seminar	24-8	7,664	0.18%	0.19	7491	0.19%	0.19	173	6472	0.18%	0.16
Other Admin. Staff Transportation	25-8	4,868	0.11%	0.12	3442	0.09%	0.09	1,426	3764	0.10%	0.09
Insurance-Prop.Liab.Malpractice	26-8	99,500	2.33%	2.50	67254	1.69%	1.68	32,246	41117	1.14%	1.00
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	1,087,290	25.49%	27.30	983791	24.79%	24.55	103,499	830214	22.97%	20.25
TOTAL Operation Expense	29-8	3,618,293	84.82%	90.84	3423595	86.28%	85.43	194,698	3114724	86.18%	75.97
Real Estate Taxes	33-3	71,986	1.69%	1.81	68057	1.72%	1.70	3,929	67471	1.87%	1.65
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	4,265,721	100.00%	**107.10**	3967900	100.00%	**99.02**	297,821	3614077	100.00%	**88.15**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1669016.4	39.13%	**41.90**	1489084	37.53%	**37.16**	179,933	1304398	36.09%	**31.81**

NORTHWOODS CARE CENTRE - DIAGNOSTICS - 12/31/2001

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 1350 from Page 22 and -1571 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-155390
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 DOES NOT EQUAL Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-79646
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.